Barnes-Jewish Hospital

BJC HealthCare

Washington University in St.Louis

Physicians

Health Questionnaire

Please answer all questions on the following pages by placing a check mark in the appropriate YES or NO column. If necessary, write additional information in the Comment section.

Patient Name: ______________________________ **Date:** ______________

Reason for visit: ______________________________

What other physicians would you like us to notify regarding your care today?

Primary Care Physician	Referring Physician or Other (please circle which)
Name:	Name:
Address:	Address:
Phone:	Phone:
Current Medications (prescribed over the counter)	**Allergies**

DO YOU HAVE A HISTORY OF	YES	NO
Heart or Circulation Problems		
Heart murmur		
Heart attack: Month/Year _________		
Irregular heart beat		
High Blood Pressure		
Low Blood Pressure		
Stroke or blood clots		
Anemia/sickle cell anemia		
Angina/chest pain		
Bleeding problems		
Swollen ankles/legs		
Cardiac Cath, EKG, Stress Test		
Lung or Breathing Problems		
Asthma – Last attack ___________		
Bronchitis		
Pneumonia		
Chronic lung disease		
Sleep apnea		
Shortness of breath		

DO YOU HAVE A HISTORY OF	YES	NO
Urinary, Kidney or Bladder Problems		
Kidney stones		
Frequent urinary infections		
Difficult urination		
Unable to hold urine		
Head or Neurologic Problems		
Seizure or blackouts		
Frequent headaches		
Weakness in an arm or leg		
Endocrine or Metabolic Problems		
Diabetes: ____diet controlled ____insulin Controlled ____ pill controlled ___		
Low blood sugar/hypoglycemia		
Thyroid problems		
Other Major Illnesses – cancer		
List:		

If Yes, circle when: resting climbing stairs walking briskly		
Frequent cough		
If Yes, do you cough anything up?		
Abnormal chest x-ray		
TB/Positive PPD		

Do you have or did you ever have:		
Physical disability/Arthritis		
Difficulty walking		
Joint replacement _______________		
Back problems		
Other: _______________________________		

	YES	NO
Digestive/Stomach/Liver Problems		
Difficulty swallowing		
Hiatal hernia/acid reflux		
Ulcers		
Jaundice (yellow skin)		
Hepatitis		
Diarrhea		
DO YOU HAVE A HISTORY OF	YES	NO
Psychosocial Problems		
Would you describe yourself as extremely anxious about your pending surgery?		
Social History Married _____ Single _____ Widowed _____ Divorced _____ Significant Partner _____		
Occupation:		
If work-related problem, please describe in detail your responsibilities:		
Children (ages):		
Tobacco use?		
Packs per day ______ for _______ years Date Quit: ________________		
Chewing tobacco? For ________ years Date Quit: _______________		
Alcohol use?		
Do you usually drink alcohol? _______ daily _______ weekly _______ monthly _______ amount		
Do you have a history of alcohol or substance abuse?		
For Women Only		
Could you possibly be pregnant?		
Date of last menstrual period:		
Number of pregnancies: __________		
Number of live births: ___________		
Other female problems:		

	YES	NO
Do you have:		
Dentures		
Chipped or loose teeth (Circle)		
Bridgework or Partial Plate		
Glasses		
Cataracts/glaucoma (circle)		
Difficulty hearing/speaking (circle)		
DO YOU HAVE A HISTORY OF	YES	NO
Surgeries		
Have you been exposed to a cough or cold in the past two weeks? Date: ________________		
Blood products or transfusion?		
If yes, any reactions?		
Any problems with anesthesia? If yes, describe:		

List Previous Surgeries	Year

Family History: Please indicate relationship and whether alive or deceased
Cancer
Cardiac
Diabetes
Seizure Disorder
Other:

COMMENTS:

____

___

Completed by: ☐ **Patient** ☐ **Other** ☐ **Signature**

Reviewed by:

(Physician Signature)

2/13/06